SENATE BILL 2615
By Tracy

HOUSE BILL 2846

By Sargent

AN ACT to amend Tennessee Code Annotated, Title 12, Title 56 and Title 71, relative to improve program integrity for medical assistance and the Children's Health Program by implementing waste, fraud and abuse, prevention detection and recovery.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. It is the intent of the legislature to implement waste, fraud and abuse detection, prevention and recovery solutions to:

(1) Improve program integrity for TennCare and the children's health insurance program (CHIP) in the state and create efficiency and cost savings through a shift from a retrospective "pay and chase" model to a prospective prepayment model; and

(2) Comply with program integrity provisions of the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as promulgated in final rules of the centers for medicare and medicaid services.

SECTION 2. As used in this act unless the context clearly requires otherwise:

(1) "CHIP" means the children's health insurance program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(2) "Enrollee" means an individual who is eligible to receive benefits and is enrolled in either the Medicaid or CHIP programs;

(3) "Medicaid" means the program to provide grants to states for medical assistance programs established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

(4) "Secretary" means the United States secretary of health and human services, acting through the administrator of the centers for medicare and medicaid services.

SECTION 3. This act shall specifically apply to:

(1) State medicaid managed care programs, including the TennCare program, operated under title 71, chapter 5;

(2) State medicaid programs operated under title 71, chapter 5; and

(3) The state CHIP program operated under title 71, chapter 2, part 16.

SECTION 4. The state shall implement provider data verification and provider screening technology solutions to check healthcare billing and provider rendering data against a continually maintained provider information database for the purposes of automating reviews and identifying and preventing inappropriate payments to:

(1) Deceased providers;

(2) Sanctioned providers;

(3) Providers who have retired or whose license has expired; and

(4) Confirmed wrong addresses.

SECTION 5. The state shall implement state-of-the art clinical code editing technology solutions to further automate claims resolution and enhance cost containment through improved claim accuracy and appropriate code correction. The technology shall identify and prevent errors or potential overbilling based on widely accepted and transparent protocols such as the American Medical Association and the centers for medicare and medicaid services. The edits shall be applied automatically before claims are adjudicated to speed processing and reduce the number of pended or rejected claims and help ensure a smoother, more consistent and more transparent adjudication process and fewer delays in provider reimbursement.

SECTION 6. The state shall implement state-of-the-art predictive modeling and analytics technologies to provide a more comprehensive and accurate view across all providers, beneficiaries and geographies within the medicaid and CHIP programs in order to:

(1) Identify and analyze those billing or utilization patterns that represent a high risk of fraudulent activity;

(2) Be integrated into the existing medicaid and CHIP claims workflow;

(3) Undertake and automate such analysis before payment is made to minimize disruptions to the work low and speed claim resolution;

(4) Prioritize such identified transactions for additional review before payment is made based on likelihood of potential waste, fraud or abuse;

(5) Capture outcome information from adjudicated claims to allow for refinement and enhancement of the predictive analytics technologies based on historical data and algorithms within the system; and

(6) Prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent or abusive until the claims have been automatically verified as valid.

SECTION 7. The state shall implement fraud investigative services that combine retrospective claims analysis and prospective waste, fraud or abuse detection techniques. These services shall include analysis of historical claims data, medical records, suspect provider databases and high-risk identification lists, as well as direct patient and provider interviews. Emphasis shall be placed on providing education to providers and ensuring that they have the opportunity to review and correct any problems identified prior to adjudication.

SECTION 8. The state shall implement medicaid and CHIP claims audit and recovery services to identify improper payments due to non-fraudulent issues, audit claims, obtain provider sign-off on the audit results and recover validated overpayments. Post payment reviews shall ensure that the diagnoses and procedure codes are accurate and valid based on the supporting physician documentation within the medical records. Core categories of reviews may include: coding compliance diagnosis related group (DRG) reviews, transfers, readmissions, cost outlier reviews, outpatient seventy-two (72)-hour rule reviews, payment errors, billing errors and others.

SECTION 9. To implement this act, the state shall either contract with The Cooperative Purchasing Network (TCPN) to issue a request for proposals (RFP) to select a contractor or use the following contractor selection process:

(1) Not later than January 1, 2013, the state shall issue a request for information (RFI) to seek input from potential contractors on capabilities and cost structures associated with the scope of work of this act. The results of the RFI shall be used by the state to create a formal request for proposals (RFP) to be issued within ninety (90) days of the closing date of the RFI;

(2) No later than ninety (90) days after the close of the RFI, the state shall issue a formal RFP to carry out this act during the first year of implementation. To the extent appropriate, the state may include subsequent implementation years and may issue additional REPs with respect to subsequent implementation years;

(3) The state shall select contractors to carry out this act using competitive procedures as provided for in title 4, chapter 12;

(4) The state shall enter into a contract under this act with an entity only if the entity:

(A) Can demonstrate appropriate technical, analytical and clinical knowledge and experience to carry out the functions included in this act; or

(B) Has a contract, or will enter into a contract, with another entity that meets the above criteria; and

(5) The state shall only enter into a contract under this act with an entity to the extent the entity complies with conflict of interest standards in the title 12, chapter 4.

SECTION 10. The state shall provide entities with a contract under this act with appropriate access to claims and other data necessary for the entity to carry out the functions included in this act. This includes, but is not limited to: providing current and historical medicaid

and CHIP claims and provider database information; and taking necessary regulatory action to facilitate appropriate public-private data sharing, including across multiple medicaid managed care entities.

SECTION 11. The following reports shall be completed by the bureau of TennCare:

(1) Not later than three (3) months after the completion of the first implementation year under this act, the state shall submit to the appropriate committees of the legislature and make available to the public a report that includes the following:

(A) A description of the implementation and use of technologies included in this act during the year;

(B) A certification that specifies the actual and projected savings to the medicaid and CHIP programs as a result of the use of these technologies, including estimates of the amounts of such savings with respect to both improper payments recovered and improper payments avoided;

(C) The actual and projected savings to the medicaid and CHIP programs as a result of such use of technologies relative to the return on investment for the use of such technologies and in comparison to other strategies or technologies used to prevent and detect fraud, waste, and abuse;

(D) Any modifications or refinements that should be made to increase the amount of actual or projected savings or mitigate any adverse impact on medicare beneficiaries or providers;

(E) An analysis of the extent to which the use of these technologies successfully prevented and detected waste, fraud, or abuse in the medicaid and CHIP programs;

(F) A review of whether the technologies affected access to, or the quality of, items and services furnished to medicaid and CHIP beneficiaries; and

(G) A review of what effect, if any, the use of these technologies had on medicaid and CHIP providers, including assessment of provider education efforts and documentation of processes for providers to review and correct problems that are identified;

(2) Not later than three (3) months after the completion of the second implementation year under this act, the state shall submit to the appropriate committees of the legislature and make available to the public a report that includes, with respect to such year, the items required under subdivision (1) as well as any other additional items determined appropriate with respect to the report for such year; and

(3) Not later than three (3) months after the completion of the third implementation year under this act, the state shall submit to the appropriate committees of the legislature, and make available to the public, a report that includes with respect to such year, the items required under subdivision (1), as well as any other additional items determined appropriate with respect to the report for such year.

SECTION 12. The state shall implement a centralized data base of all claims-based data for medicaid, CHIP or other public health programs, regardless of whether those beneficiaries receive their benefits directly from the public system or through one of the outsourced private health insurers, and ensure that:

(1) The data base contains "unadulterated" claims data that is the complete data set as submitted by the providers before any risk of data loss or manipulation as claims pass through processing systems; and

(2) The analytics are run on the complete data set to ensure the integrity and appropriate level of payment, not only for the direct-beneficiaries' care, but also in the establishment of the capitation rates to the managed care plans.

SECTION 13. It is the intent of the general assembly that the savings achieved through this act shall more than cover the costs of implementation. Therefore, to the extent possible, technology services used in carrying out this act shall be secured using a shared savings model, whereby the state's only direct cost will be a percentage of actual savings achieved. Further, to enable this model, a percentage of achieved savings may be used to fund expenditures under this act.

SECTION 14. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 15. This act shall take effect July 1, 2012, the public welfare requiring it.